



## ACCIDENT REPORTING AND INVESTIGATION

VERSION NUMBER: 1.1

DATE OF REVISION: 13 SEPTEMBER 2004

DATE OF ISSUE: 12 APRIL 2002

This procedure covers:

- reporting all accidents in the accident book
- reporting to HSE when RIDDOR requires it
- investigating any mishaps which are reported to HSE or which have serious implications
- modifying procedures or Safe Systems of Work if investigation shows this to be necessary.

### INTRODUCTION

#### ACCIDENT REPORTING

- The dictionary definition of an accident as “an unforeseen event” is not particularly helpful in the context of health and safety. It is more useful to categorise such events which happen in the workplace (referred to as “mishaps” in this procedure) as follows:
- **Incident** – any unplanned occurrence that leads to damage to property, plant or equipment.
- **Accident** – any unplanned occurrence that leads to the injury of personnel or other persons involved in our activities, including diseases or medical conditions contracted as a result of our activities.
- **Dangerous occurrence** – any unplanned occurrence that is listed in Schedule 2 of the **Reporting of Injuries, Diseases & Dangerous Occurrences Regulations 1995 (RIDDOR)**.
- **Near miss** – any unplanned occurrence (except Dangerous occurrence) that does not lead to injury of personnel or damage to property, plant or equipment, but may have done in different circumstances.

In this procedure we use the phrase “accident reporting” or “accident reports” to cover the reporting of any of the 4 categories listed above.

We require staff to report all mishaps which occur at work in any of the categories listed above. Most NERC Sites use the Stationery Office accident book ISBN0-S176-2603-2, for this purpose; it combines the requirements of social security and health and safety regulations. The Stationery Office book is not wholly satisfactory, but we suggest that those sites using it continue to do so until a better system is developed. This will probably be an electronic system based on the one being set up for BAS.

Under RIDDOR, NERC is required to report certain categories of mishap to the Health & Safety Executive (HSE). In this procedure, these are referred to as “reportable accidents”. The regulations use different definitions from the ones shown above.

Each local safety adviser has a copy of the HSE’s Guide to RIDDOR and pads of the forms used for notifying HSE of reportable accidents to HSE. Reporting is more easily done via the web (For further information regarding Dangerous Occurrences can be found on the website: <http://www.riddor.gov.uk/> ) or Telephone (0870 1545500). The guide gives detailed definitions of “reportable accidents”, which are summarised in [Appendix I](#).

## **INVESTIGATION**

All mishaps recorded in the accident book should be investigated. Informal investigation will be sufficient for minor mishaps. Major mishaps, included all those reported to HSE under RIDDOR, should be formally investigated using the following system. A team consisting of a senior manager, a member of the site administration staff and the local safety adviser should investigate any accidents which are reported to HSE, and any other accidents which have serious implications. A Union Side safety representative should be invited to be a member of any accident investigation team. The team should produce a written report which should make recommendations for preventing a recurrence of the accident and a timescale for implementing the recommendations.

**You must report all accidents to the local Accident Reporting System**

## **CONTENTS:**

- [Operational procedure](#)
- [Roles and responsibilities](#)
- [System flow diagram](#) What might go wrong? – probable sources of system and individual failure
- [Management, monitoring and auditing](#)

### **Appendices:**

- [Appendix I: Summary of Regulations](#)
- [Appendix II: Specific HSE guidance](#)

## **NOTE:**

The law requires all mishaps in the UK to be reported to the employer, and specified serious mishaps to the HSE. Mishaps which occur on ships must additionally be reported under the separate arrangements set out in current merchant shipping legislation and “M” notices. Mishaps which happen to staff working abroad should be reported in the same way as if they were working in the UK.

**Acknowledgements: this procedure is based on material produced by Richard Pope, Neil Wilson and the Institution of Occupational Safety & Health.**

**Management involvement**

Management is responsible for ensuring that:

- all mishaps are recorded to the local accident reporting system
- the book is monitored regularly
- mishaps falling within the scope of the RIDDOR Regulations are reported to HSE
- mishaps reportable to HSE, and other mishaps with serious implications, are investigated
- recommendations arising from investigation reports are acted on.

**Availability of accident books**

Keep accident books where they are easily available to staff. Staff will normally record mishaps themselves unless they are incapacitated, in which case a colleague or manager must make the record. Once the information has been entered into the book, to comply with the Data Protection Act this page should be removed and passed to the appropriate person/department that looks after these records.

**Quarterly returns to Swindon Office**

An electronic form will be e-mailed to the relevant person at each Site to record all accidents, incidents and near misses that occurred during each quarter (end of March, June, September and December). This form should then be returned to the assistant NERC Safety Adviser at Swindon. We recommend that Research Centres should also carry out their own monitoring to identify trends in mishaps. The information is needed in order to:

- compile returns and statistics for the NERC Safety Committee and Audit Committee
- enable the NERC Safety Adviser to monitor trends
- enable Research Centre Directors to take remedial action.

**Monitoring of accident reports**

The relevant nominated person/s should check the accident reports regularly – ideally weekly – to ensure that;

- remedial action has been taken where necessary
- RIDDOR mishaps are reported to HSE
- RIDDOR and other serious mishaps are investigated.

**Investigation team**

Minor mishaps should be investigated informally by the line manager, using the principles set out below. The Research Centre Safety Director should appoint a team to investigate major accidents, which include those defined as “reportable accidents” in [Appendix I](#) and any others which have serious implications. A team, normally consisting of a senior manager, member of the Site administrative staff and local safety adviser, should carry out investigations and produce written reports. A Union Side safety representative should be invited to be a member of any accident investigation team. The team’s aims should be to determine:

- the chain of events leading up to the accident
- the causes of the accident
- contributory factors which affected the seriousness of the consequences
- remedial actions to prevent a recurrence
- risk classification ([see NERC Procedure no 12, Risk assessment & risk management](#))
- breaches of the law or NERC Procedures
- whether NERC policies or Procedures need to be amended.

At least one of the staff involved in investigations must understand the reporting regulations, and have a working knowledge of any other regulations which apply to the activity being carried out when the mishap happened.

**Dealing with the aftermath of the accident**

The most senior manager available should deal with the emergency promptly and positively:

- take control at the scene
- call for emergency services if necessary
- take action to prevent secondary accidents
- identify sources of evidence at the scene
- prevent evidence from being tampered with or removed
- decide who should be notified.

### **Collecting evidence for the investigation**

Collect relevant information:

- look at the overall picture first
- interview witnesses separately – to ensure that each tells their own story without influence from others
- interview at the scene whenever possible
- put witnesses at their ease – you are establishing what happened, not allocating blame
- ask questions to draw out information
- feedback to witnesses what you understand they said, to check that your version is correct
- take photographs
- encourage witnesses to let you know if they subsequently remember anything else that may be relevant.

### **Gathering information**

- Keep a camera and the other equipment listed below in a grab bag kept in a specified place so that it is always available for immediate use
- take a notebook or clipboard with paper
- take tie-on labels, permanent markers, sealable plastic bags and containers to label and collect items which need to be examined or used as evidence
- take photographs of the accident area
- preserve as evidence anything which appears abnormal, such as distorted pieces of machinery, foreign objects, items showing signs of spillage or leakage
- examine paper evidence such as condition reports, maps or plans, specifications for equipment, maintenance reports, suppliers' manuals, competence and training records.

### **Photography**

At the scene of the accident, photographs can record:

- orientation of the scene
- weather conditions
- witnesses' view of the scene
- relative positions of debris
- evidence of deterioration, abuse, lack of maintenance of equipment.

Photographs can also be used later in the investigation to illustrate:

- dismantling of equipment
- the sequence of failure, e.g. fatigue failures in metal
- evidence overlooked, or hidden, earlier in the investigation
- the written report.

### **Witnesses**

- interview them separately so that they can speak freely, without embarrassment and with no influence from others
- ask open questions and do not lead witnesses
- interview them at the scene of the accident if possible
- make the interview as informal and unthreatening as possible
- use feedback at the end of the interview to ensure that you have recorded their testimony accurately.

### **Points for investigation team to consider**

Analyse and evaluate all significant causes:

- establish the immediate causes, e.g. failures to follow procedures, sub-standard equipment
- establish underlying causes, e.g. personal factors, pressure of work
- determine the most critical causes
- check the adequacy of the management system – were the policy or procedures adequate, did staff comply with them?

Recommend remedial action:

- consider alternative methods of control
- reduce the likelihood that the event will recur
- mitigate the consequences of the event recurring
- take immediate remedial action, even if it is only a holding one
- take permanent action as soon as possible
- document all your findings in a written report.

Review findings and recommendations:

- the report writer's manager and the local safety adviser should review the report.
- they should evaluate the quality of the report and give feedback on how it could be improved.

Monitoring

- check that the recommended remedial actions have been taken on time
- check the effectiveness of these actions
- look for trends in serious events.

#### **Authorisation**

The Research Centre Safety Director must sign the completed major event investigation report to show that he/she accepts its recommendations and requires them to be carried out.

#### **Record actions**

When the recommendations have been carried out, the manager responsible must record on the report the date when the work was completed.

#### **Encourage and monitor feedback**

At all stages, encourage anyone involved in an event and/or investigation to give further information, correct or amplify earlier testimony or comment on the effectiveness of the measures taken to mitigate the effects of the mishap or prevent its recurrence.

#### **Involve site safety committee**

The committee should meet to discuss and review the findings of the investigation team.

**Director:** responsible for:

- ensuring that this procedure is followed
- appointing a senior manager to carry out investigations.

**Head of Site/Head of Administration:** responsible for:

- ensuring that staff are aware of the need to report accidents
- ensuring that accident reports are checked regularly
- arranging for reportable accidents to be notified to HSE
- participating – or nominating a member of staff to participate – in investigations.

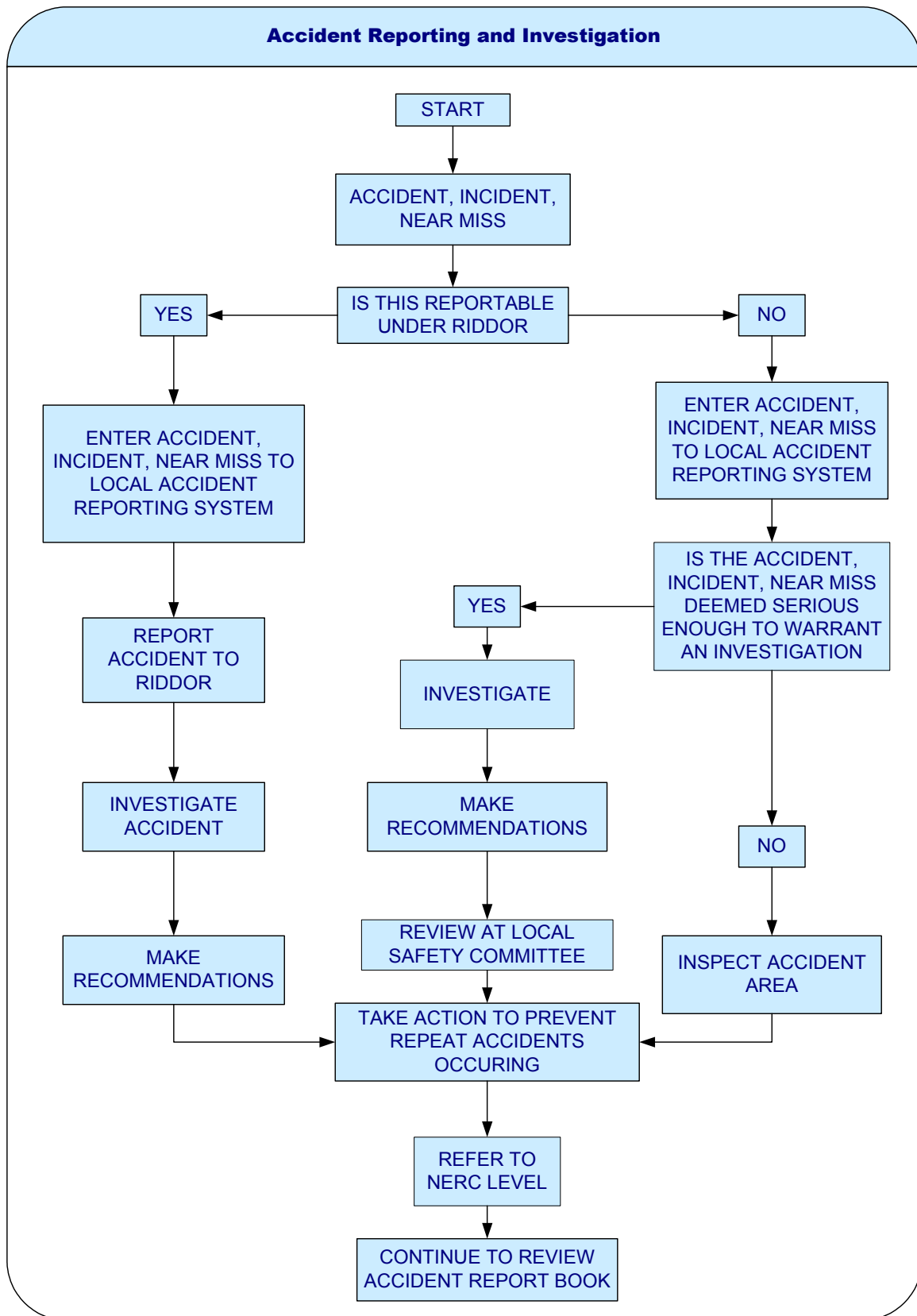
**Division/Section/Group/Unit heads:** must:

- ensure that their staff enter all workplace mishaps to the local accident reporting system
- notify site head of administration of reportable accidents

**Competent persons:** at least one of the staff involved in accident investigations must understand the reporting regulations, and have a working knowledge of any other regulations which apply to the activity being carried out when the accident happened.

**Staff:**

- must enter to the local accident reporting system details of any workplace mishap which affects them, unless they are incapacitated, in which case a colleague or manager must make the entry
- must inform their line manager.





**Management:**

**Failure to record mishap in book:** if an mishap is serious or has long-term consequences, staff may decide to sue NERC for compensation. If the mishap is not recorded and, if appropriate, investigated, it will be more difficult for NERC to defend the case.

**Remedy** – Encourage accident/incident near miss reporting.

**Failure to notify HSE of a reportable accident:** HSE can prosecute NERC or an individual for failing to notify them of a reportable accident. **Remedy** – encourage managers to inform site administrative staff of all serious mishaps so that they can notify HSE without delay if it is a reportable accident.

**Failure to carry out an investigation of a serious mishap:** this will also make it more difficult for NERC to refute a claim for compensation. **Remedy** – the weekly check of the accident reports should show up any serious mishaps which have not already been notified to site administrative staff.

**MAKE SURE THE MESSAGE IS CONVINCING, CONSISTENT AND ENFORCED**

**Staff:**

**Failure to record mishap in book:** it is important for staff to record mishaps in to the local accident reporting system. If they fail to do so, and subsequently suffer consequences which lead them to claim compensation, they may find it more difficult to substantiate their claim.

**Remedy** – report a mishap as soon as it happens. If you are away from base on fieldwork or other business, make a note of what happened and report it to the local accident reporting system as soon as you return to base. If the mishap is serious, contact base and ask your manager to make an entry on your behalf.

**Management:**

The management of mishap reporting and investigation requires:

- good, clear lines of communications between staff at all levels
- an awareness of the importance of recording mishaps
- competence in carrying out and reporting on investigations.

**Monitoring:**

The monitoring of mishap reporting and investigation requires:

- review of the accident records weekly
- managers to ensure that their staff report all mishaps in the accident reports
- reviewing statistics to look for trends.

**Auditing:**

The auditing of accident reporting and investigation requires:

- checking that staff are complying with this procedure
- assessing management and staff attitudes by interview.



## Notes for the site manager

### When do I need to act?

#### Death or major injury

If there is an mishap connected with work and:

- your employee, or a self-employed person working on your premises is killed or suffers a major injury (including as a result of physical violence); or a member of the public is killed or taken to hospital;
- you must notify the enforcing authority\* without delay (e.g. Telephone). They will ask for brief details about your business, the injured person and the accident; and within ten days you must follow this up with a completed accident report form (F2508) either via the web (<http://www.riddor.gov.uk/>) or in writing using the same form.
- \*The enforcing authority may be the HSE or the local council. The name, address and phone number of the enforcing authority should be shown on the poster entitled "Health & safety law: what you should know" which must be clearly displayed at every site.

#### Over-three-day injury

If there is a mishap connected with work (including an act of physical violence) and your employee, or a self-employed person working on your premises, suffers an over-three-day injury you must send a completed accident report form (F2508) to the enforcing authority\* within ten days. An over-three-day injury is one which is not major but results in the injured person being away from work or unable to do their normal work for more than three days (including non-work days)

#### Disease

If a doctor notifies you that your employee suffers from a reportable work-related disease then you must send a completed disease report form (F2508A) to the enforcing authority\*. For further information regarding Diseases can be found on the website: <http://www.riddor.gov.uk/>

#### Dangerous occurrence (near miss)

If something happens which does not result in a reportable injury, but which clearly could have done, then it may be a dangerous occurrence which must be reported immediately (e.g. by telephone). For further information regarding Dangerous Occurrences can be found on the website: <http://www.riddor.gov.uk/>

All Dangerous Occurrences must be reported within ten days on the web (<http://www.riddor.gov.uk/>) or by completing the accident report form (F2508).

The HSE free leaflet *MISC310, RIDDOR reporting: information about the new incident centre* describes the ways in which you can now inform HSE of reportable accidents at your site, using

- post
- internet
- phone
- fax.

The aim is to make reporting as simple as possible, to encourage employers to report accidents which fall under the RIDDOR Regulations.

Definitions of major injuries, dangerous occurrences and diseases are given in the HSE publication "A guide to the reporting of injuries, diseases and dangerous occurrences", a copy of which is held at each site.

---

## APPENDIX II: SPECIFIC HSE GUIDANCE

---



Each site has a copy of the HSE publication *A guide to the Reporting of Injuries, Diseases & Dangerous Occurrences Regulations 1995*, HSE Books 1999, ISBN 0 7176 2431 5, price £7.95, which gives full details of the reporting requirements. Further information can also be found on the website <http://www.riddor.gov.uk/>.